

## ARIZONA INTERSCHOLASTIC ASSOCIATION

7007 North 18th Street, Phoenix, Arizona 85020-5552

Phone: (602) 385-3810



## 2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_ Hospital Preference \_\_\_\_\_

In case of emergency, contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C) \_\_\_\_\_

Explain "Yes" answers below.

Circle questions you don't know the answers to.

	YES	NO		YES	NO
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	19) Were you born without, are you missing. Or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>	20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods, or stinging insects? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>	21) Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>	23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	25) Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	27) When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):	YES <input type="checkbox"/>	NO <input type="checkbox"/>	30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
* 10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the boxes below):	<input type="checkbox"/>	<input type="checkbox"/>	31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
* 11) Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (If yes, circle affected area in the boxes below):	<input type="checkbox"/>	<input type="checkbox"/>	32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Calf/Shin	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>			
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>			
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>			
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>			
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>			
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>			

## FEMALES ONLY

	YES	NO
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?	_____	_____
40) How many periods have you had in the last year?	_____	_____

Explain "Yes" answers here:




## 2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Physician should fill out this form with assistance from the Parent or Guardian.)

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Patient History Questions: Please tell me about your child....</b>	<b>YES</b>	<b>NO</b>
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercised -induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family History Questions: Please tell me about any of the following in your family....</b>	<b>YES</b>	<b>NO</b>
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:		
Enlarged Heart:	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm problems:	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)	<input type="checkbox"/>	<input type="checkbox"/>

<b>Explain "Yes" answers here:</b>

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of athlete: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## 2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)

Vision R 20 / \_\_\_\_ L 20 / \_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS *
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

\* Multi-examiner set-up only.

† Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_

\_\_\_\_\_

Cleared without restriction

Not cleared for:       All sports       Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Exam Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD / DO / NP / PA-C



**Arizona Interscholastic Association, Inc.**

**Mild Traumatic Brain Injury (MTBI) / Concussion**

**Annual Statement and Acknowledgement Form**

I, \_\_\_\_\_ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion/HeadsUp/youth.html>) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

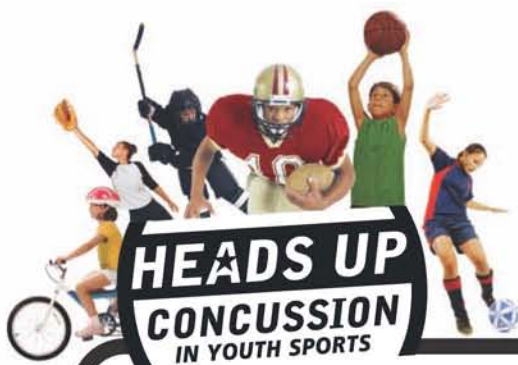
Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## HEADS UP CONCUSSION IN YOUTH SPORTS

## A Fact Sheet for **ATHLETES**

### WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

### WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

### WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.

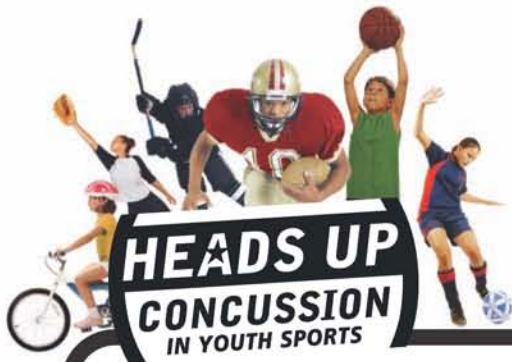
- **Get a medical check up.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

### HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and fit well
  - Used every time you play

*It's better to miss one game than the whole season.*



## HEADS UP CONCUSSION IN YOUTH SPORTS

## A Fact Sheet for PARENTS

### WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

### WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

#### Signs Observed by Parents or Guardians

*If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:*

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

#### Symptoms Reported by Athlete

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Does not “feel right”

### HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

### WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

- 1. Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
- 2. Keep your child out of play.** Concussions take time to heal. Don’t let your child return to play until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
- 3. Tell your child’s coach about any recent concussion.** Coaches should know if your child had a recent concussion in ANY sport. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

***It’s better to miss one game than the whole season.***